

PERSONAL INFORMATION . . .

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Phone #: Home (____) ____ - _____ Mobile (____) ____ - _____ Work (____) ____ - _____

Email (for appointment reminders + specials): _____

Occupation: _____ How did you hear about us? _____

Method of Payment (circle all that apply): GIFT CERTIFICATE INSURANCE CASH/CREDIT/CHECK

MEDICAL HISTORY . . .

1. Physician/Chiropractor: _____

2. Currently Under Doctor's Care? YES NO Conditions: _____

3. Recent/Past Injuries & Surgeries: _____

4. Medications: _____

5. Hobbies/Exercise: _____

6. Conditions - WE MUST KNOW FOR YOUR SAFETY! (circle all that apply):

Allergies (acutane or shellfish) List: _____

- | | | |
|-------------------------------|-----------------------|----------------------------|
| Asthma | Fever Blisters | Lupus |
| Back/Shoulder Conditions | Headaches/Chronic | Metal bone pins or plates |
| Broken Bones | Head or Neck Injuries | Pacemaker |
| Cancer (current or remission) | Hepatitis | Psychological |
| Cardiac Problems | Herpes | Sinus Problems |
| Diabetes | High Blood Pressure | Skin Diseases |
| Eczema | Hypertension | Surgeries |
| Epilepsy | Hysterectomy | Urinary or Kidney Problems |
| | Immune Disorders | Varicose Veins |

MASSAGE . . .

1. Have you received a professional massage before? YES NO

2. Are you pregnant or planning? YES NO

3. Are you wearing contacts? YES NO

4. What do you need out of your massage? _____

5. Questions/Concerns? _____

PEDICURE, MANICURE, GEL POLISH •••

1. With respect to your feet or hands, which of these conditions do you experience? (circle all that apply)

- | | | | | |
|--------------|--------------|------------------|-----------------|---------------|
| Cold Feet | Peeling Skin | Skin Fungus | Tired Sensation | Corns |
| Dry Skin | Sweating | Nail Fungus | Heavy Sensation | Plantar Warts |
| Cracked Skin | Hot Feet | Discolored Nails | Foot Odor | |
| Itchiness | Blisters | Thick Nails | Callus Build-up | |

2. What improvements would you like to see? _____
3. Are you being treated for diabetes? YES NO
4. Allergies List _____
5. Current medications _____
6. Do you have sensitivity to UV light? YES NO

SPA TREATMENT, FACIAL & WAXING •••

- | | | |
|--|-----|----|
| 1. Is this your first treatment? | YES | NO |
| 2. Are you taking birth control? | YES | NO |
| 3. Do you wear contact lenses? | YES | NO |
| 4. Do you smoke? | YES | NO |
| 5. Are you currently being treated with chemotherapy? | YES | NO |
| 6. Have you used any Glycolic or Alpha Hydroxy Acid products in the last 48 hours? | YES | NO |
| 7. Are you currently using Retain A products, Acutane or Renova? | YES | NO |
| 8. Have you recently received a chemical peel? | YES | NO |
| 9. Are you exposed to sun on a daily basis? | YES | NO |
| 10. Do you regularly use a tanning bed? | YES | NO |
| 11. Do you have any allergies to cosmetics, foods, seaweed, shellfish, or drugs? | YES | NO |
- If yes, please list _____

This is to acknowledge that I have been informed of all aspects of my waxing service and that I understand that I may experience possible redness and or skin irritation's. It is with this understanding that I agree to have these services and I accept all responsibility for such thereby releasing the Spa and the service provider from liability. I am over/under twenty one years of age.

SIGNATURE: _____ DATE: _____